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*Sara Smith Specialist Registrar in General Psychiatry, Hillcrest Psychiatric Unit, Quinneys Lane, Redditch Vincent Baxter Community Forensic Psychiatric Nurse, Martin Humphreys Senior Lecturer in Forensic Psychiatry, Reaside Clinic and University of Birmingham

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JOE HERZBERG AND ELISABETH PAICE

Psychiatric training revisited – better, worse or the same?

AIMS AND METHOD

To evaluate psychiatric training in one deanery following a programme of site visits, interviews with trainers and trainees, reports, and recommendations. To assess the findings in the context of NHS training requirements. Information was collected by semi-structured interviews and questionnaire surveys.

RESULTS

Forty-three sites were visited, training is generally of a high standard and most trainees are satisfied with their posts. There are significant problems in delivering sufficient community experience to general practice trainees and deficits in availability of multi-professional training programmes.

CLINICAL IMPLICATIONS

College tutors should work to ensure that trainees have access to shared learning occasions with non-medical health professionals to meet the NHS training agenda.

The postgraduate deans commission training to speciality standards set by the Medical Royal Colleges. The Royal College of Psychiatrists has published clear guidance on the standards expected for basic and higher professional training (Royal College of Psychiatrists, 1998, 1999), and these guidelines are updated regularly. Additionally, in the NHS professionals are re-defining and extending their traditional roles, and this has major implications for workforce development, which will need to be supported by multi-professional training (Department of Health, 2000).

At the time of the study, the North Thames deanery was responsible for training approximately a sixth of the psychiatric trainees in the UK. We reviewed psychiatric training on all sites in North Thames in 1996–1997 (Herzberg *et al*, 1999) and found that, despite a high level of satisfaction expressed by trainees, deficiencies in educational and safety standards were found. Trusts and trainers were made aware of these deficiencies by immediate feedback and a written report. A subsequent cycle of visits was carried out in 1999–2000 to see whether improvement had occurred.

Method

Training sites visited in the first survey were revisited. College tutors provided information on a structured

questionnaire about the staffing levels, general characteristics of their NHS trusts and their training programmes. The questionnaire was identical to that used in the previous cycle of visits in 1996–1997. Additionally, structured interviews were carried out with senior house officers (SHOs) and specialist registrars (SpRs) on each site. The interviews lasted approximately half an hour per group and the responses were entered onto a form.

Results

All 43 psychiatric training sites in North Thames were revisited. Of 374 SHOs on the deans' database, 237 (63%) were interviewed, and of 161 SpRs 101 (63%) were interviewed. Our experience is that the number of trainees available for interview at any time is approximately 12–15% less than the full establishment, because of leave or vacancies (Paice *et al*, 1997, 2000). The true response rate was therefore over 75% for each group. Tables 1 and 2 compare key findings on the 1996–1997 visits with those of the 1999–2000 visits.

General practitioner vocational training scheme posts

The percentage of general practitioner (GP) vocational training scheme posts without community sessions

**Table 1. Educational findings over a 3-year period**

	GPVTS posts without community sessions	Comprehensive induction programme	ECT supervision satisfactory	Multi-professional case conferences	Multi-professional audit meetings	Bleep-free local training programme
1996–1997	9/18 (50%)	27/40 (68%)	10/29 (34%)	24/40 (60%)	29/37 (78%)	15/43 (35%)
1999–2000	3/24 (12%)	42/43 (98%)	19/26 (73%)	28/43 (65%)	26/36 (72%)	28/43 (65%)

GPVTS, general practitioner vocational training scheme; ECT, electroconvulsive therapy.

Table 2. Availability of psychotherapy supervision over a 3-year period

	Dynamic psychotherapy	Cognitive–behavioural psychotherapy	Family therapy
1996–1997	37/42 (88%)	39/43 (91%)	31/43 (72%)
1999–2000	41/43 (95%)	42/43 (98%)	32/43 (74%)

decreased from 9/18 to 3/24 (Table 1). In 1999–2000, nine offered one session, five offered two sessions and the rest offered between three and five community-based sessions.

Induction

More departments offered comprehensive induction programmes (Table 1). In 1999–2000 induction occurred on 42 sites, lasting a mean of 2.6 half-day sessions (range 0.5–6 sessions).

Electroconvulsive therapy

In 1999–2000 an electroconvulsive therapy (ECT) induction session occurred on 34 (94%) sites where trainees were expected to participate in the ECT rota, an identical finding to the first survey. However, ECT supervision was deemed satisfactory in over twice as many units in 1999–2000 as in the previous study (Table 1).

Training meetings and supervision

There has been little change in trainees' ability to access multi-professional training over this period. Table 1 sets out some key educational findings in the two periods surveyed. There was little change in trainees' access to case conferences, with regular multi-professional input between the two surveys. Journal clubs remained largely medical events and on 41 sites where these were run in 1999–2000, only 11 had multi-professional input, compared with 8 in 1996–1997. Audit meetings were slightly less likely to be multi-professional over the two periods surveyed.

In 1999–2000 trainees on two sites complained of difficulty in attending the local training programme on a regular basis, compared with similar difficulties for trainees on six sites in 1996–1997. However, marked improvements have occurred in the provision of 'bleep-free' local training time (see Table 1). Interviews with SHOs identified nine posts in which supervision was

stated to be unsatisfactory and discussions with SpRs revealed three posts with poor supervision. Supervision in psychotherapy was widely available (see Table 2), with modest increases in availability of supervision in major modalities across the deanery area.

Workload issues – 1999–2000

SHOs described the on-call rota as satisfactory on 29 sites. They felt that the general daytime workload in their posts were satisfactory on 36 sites. Twenty-three SHOs reported that in at least one post they were expected to carry out inappropriate duties (routine filing, phlebotomy or portering). SHOs graded their overall group view of the quality of their satisfaction with posts as average on seven, good on 26 and excellent on three sites.

SpRs in psychiatry carry out non-resident on-call duties. On all 34 sites where SpRs were interviewed, their daytime workload was deemed satisfactory. On three sites SpRs complained of inappropriate duties. SpR's overall satisfaction with posts was graded poor on one site, good on 20 and excellent on seven.

Discussion

It is clear that the majority of trainees were satisfied with the training in their posts, but there remains scope for improvement in several areas. The deanery has been pressing to improve the quality of the training experience offered to GP vocational training schemes to ensure that the experience reflects a suitable clinical case-load and setting mix for primary care. The number of posts offering more than one community oriented session has risen since the 1996–1997 visits but generally the hospital–community balance remains inappropriately skewed to secondary care. There is a constant tension between the need to improve training experience for GPs and the need for NHS trusts to ensure that wards are covered.



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Induction arrangements have improved in the study period. Similarly, comprehensive arrangements occur on the majority of sites where ECT is given. The Royal College of Psychiatrists is now inspecting ECT facilities and training and accrediting clinics. It remains a matter of concern that on seven (27%) sites supervision is unsatisfactory. Feedback received at deanery visits indicates that this is often because the consultant responsible for the service is timetabled to be off site when treatment is being given. Phlebotomy services are often poor on isolated community sites away from the general hospital. We know from feedback that many NHS trusts are addressing this issue by training nurses to assist in this task.

The Department of Health document, *A Health Service of all the Talents* (Department of Health, 2000), has emphasised the importance of multi-professional training in the service setting. Unfortunately, the majority of trainees in this study had little access to meetings in which they could share knowledge and discuss and debate issues with other health professionals. However, this may be partially explained by the fact that doctors have traditionally enjoyed easier access to protected study leave time and money than other professional groups. However, there are also doubts raised about the value of multi-professional learning. Frankly, there is a dearth of studies assessing multi-professional training in secondary care. However, in primary care Mann *et al* (1996) have shown benefits in collaborative working by delivering a multi-professional heart health programme to doctors and other health and social care professionals, and in undergraduate courses similar benefits have been described (Wahlstrom *et al*, 1997; Parsell *et al*, 1998). For a review of this topic see Herzberg (1999). Psychiatrists face a significant challenge to ensure that trainees have access to educational programmes that promote learning

of core skills, attitudes and knowledge necessary for practice in the speciality, but also promote shared learning with other clinical health professionals.

This study demonstrates that psychiatric training had improved over a 3-year period in one deanery, but there will need to be a considerable amount of work undertaken to meet the challenges of the new NHS training agenda.

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***Joe Herzberg** Associate Dean of Postgraduate Medicine (north-east London) **Elisabeth Paice** Dean Director, Thames Postgraduate Medical and Dental Education (now London Department of Postgraduate Medical and Dental Education), 20 Guilford Street, London WC1N 1DZ

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S. CASSAR, A. HODGKISS, A. RAMIREZ AND D. WILLIAMS

Mental health presentations to an inner-city accident and emergency department

AIMS AND METHOD

To study the presentation, assessment and management of all patients attending St Thomas' accident and emergency (A&E) department with overt mental health problems. The method included a pragmatic definition of 'overt mental health problems' and a range of strategies to maximise case ascertainment.

RESULTS

The department saw 565 presentations in a 3-month period. Patients were predominantly young, male, single, unemployed, housed outside the area served by the local primary care group and presented outside normal working hours.

CLINICAL IMPLICATIONS

This study confirms that A&E departments may be the most frequently used setting for urgent mental health assessments in central London. The patients attending differ from those using community mental health teams. It is argued that mental health liaison services based in inner-city A&E departments should be developed.

Accident and emergency (A&E) departments are the most frequently used facility for urgent mental health

assessments both within and outside office hours (Johnson & Thornicroft, 1995). This finding holds even